in planning and making possible this symposium, his energy and skill made it one of the most successful conferences ever sponsored by the Academy. Special mention should be made of the help given by Marvin Lieberman, who is the Committee's staff consultant in medical care working under a career grant from the Health Research Council of the City of New York. Miss Antoinette A. Gattozzi, assistant to Mr. Becker and staff editor, was responsible for most of the administrative arrangements for the Conference and for the editorial work in preparing these papers for publication.

HAROLD JACOBZINER
Conference Chairman

Prefatory Remarks

In the next decade the health section of our national economy will be confronted with an array of economic and socal pressures against a background of ever-increasing technical and medical advances. These factors are certain to accelerate the rate of the changes, already evident, in the organization and financing of medical services. Consumer demands for health care will continue to rise, primarily because new medical knowledge and skills offer greater opportunities for personal fulfillment and well-being. Demands will rise, also, because of higher levels of public education, because of the increasing number of people in those age groups that make the heaviest demands on the nation's health services and, of course, because of the inevitable increases in both public and private funds available for health care. From almost every point of view health care can be expected to be one of the most, if not the most, rapidly expanding components of our personal standard of living; similarly, it will rank as a major concern of government.

These circumstances are ample explanation for the current ferment of public and professional concern with such questions as: How can the organization of health services be improved to provide a high quality of health care most economically? There is a general public belief, shared by many in the health professions, that improvements in the organization of health care can be made that would both raise the quality of services and lower the cost to the consumer. Concern with cost

and quality, with economy and effectiveness, implies a concern with greater productivity of personnel through the optimum use of physical plants and equipment and an appropriate division of labor. This introduces into medical services the elements of organization and administration. Without the factors of organization and administration—without an orderly pattern for the provision and financing of a service—the realization of concepts of economy and effectiveness is frustrated.

Questions on organization and quality of care cannot be explored without raising other questions—issues of social values and the pertinent question of financing. Any discussion of financing and source of funds involves social values basic to considerations for improving the organization of health services.

The complex segments that constitute the whole of the health sector —institutions, the network of various professional groups, the government and voluntary insurance agencies paying for care—have deep roots in past experience and concepts developed over a period of time. These relationships are not modified by decree, however well intended.

It is one thing to have firm beliefs supported by pilot demonstrations that focus on the directions for national organization and an orderly pattern of financing health care, but quite another thing to expect changes to come smoothly and quickly. The greatest strength of a free and democratic society is the absence of a single and unchallenged authority, one that might establish a monolithic system of health care. For a long time to come the health-care complex will move forward in pluralistic fashion, hopefully keeping what seems best and discarding what does not work.

The function of planning and of establishing priorities is, however, necessary for preserving and making effective the knowledge gained from the experimentation implicit in our pluralistic efforts. Without greater emphasis on, and more effective use of mechanisms for planning—evaluating and implementing what is learned—there is too great a danger that the result of experimentation will be a needless multiplicity of fragmented and uncoordinated programs.

The process of continuous experimentation and evaluation is the material for debate and, subsequently, for decision-making. For several decades many knowledgeable persons have urged that the hospital and the organized clinic were the basic administrative units around which the health services should be organized. Nevertheless, broad implemen-

tation of this agreement has been slow and uneven. Pilot programs of innovations toward this end, however, are increasing in number, variety, and importance. This group of papers is evidence of the many discussions and debates that are both the substance of and the process out of which the future shape of health care evolves.

These papers deal with the medical advances and challenges of the next ten years and with the growing concern for the patient as a human being with a right to the best in health care, provided in a manner consistent with today's standards of equality and dignity. The source of funds for financing personal health care, and whether care is rendered under the auspices of the public or under the private sector of financing and organization, should not modify the standards for an acceptable quality of care or the right of the patient to equal treatment with all other patients. These papers help to bring into focus the roles and concerns of the health-service institutions—the public health agency and the hospital—and of the physician, who, in the final analysis, has the critical responsibility for the patient.

The rising cost of in-hospital care to bed patients, which far exceeds the rise in the costs of the other segments of health care, plus the increased per capita consumption of hospital services, is directing attention to ways of making the hospital's skilled professional and paramedical services and specialized facilities easily available to physicians and the public *outside* the inpatient setting. As the hospital begins to provide for more ambulatory patients than inpatients, we are witnessing the most important change in the organization of health care that has occurred since the widespread adoption of the voluntary prepayment mechanism for financing acute hospital care.

There is much to be learned about this new and expanding role of hospitals in making ambulatory care—and home care and skilled nursing care for the convalescent or chronically ill patient—available to the patient who desires care similar to that given the paying patient. Problems of hospital-physician relations, reimbursement for professional and other services, and the over-all question of financing are among the administrative obstacles yet to be overcome by the adoption of procedures found workable in various demonstrations and pilot programs. In this context the pilot experiences judged to be impractical have equal importance with those approaches that seem to work best. It is the intent of these papers to provide a measure of insight into this aspect of the

new administrative task of every hospital, a task no longer primarily confined to the needs of the bed patient. The hospital's challenging new role, as one part of the community matrix of health and welfare services, is to provide health care for a neighborhood or for a total community consisting of both sick people who want to be well and to lead productive lives—and well people who want to stay well.

Underlying the many unresolved problems in meeting the demands of the consumer for improvements in the organization of health care is the old and familiar one of the source of necessary financing. There is no ready or simple answer. Although for several decades it has been an accepted fact that acute hospital care cannot be financed by having the sick pay for care at the time of illness, the only major breakthrough in the social and economic aspects of health care over the past quarter-century has been the widespread adoption and public participation in voluntary health insurance. Some of the problems the health-care sector faces today, and the source of public concern about costs, arise from the fact that voluntary health insurance has been limited largely to in-hospital care and indemnity payments to help meet the cost of surgical care. Efforts to provide a comprehensive or all-inclusive organized health service on a prepayment basis have received much attention, yet these plans have not, in general, been widely adopted. The reasons for this have not been fully explored or fully understood.

Those fragments of health care that are financed from health insurance or tax funds have tended to be better financed, on a relative basis, than services that the sick must pay for out-of-pocket at the time of illness. In fact, many types of care are not extensively available because of the absence of adequate financing mechanisms. There is, consequently, greater use of hospital services by bed patients seeking both diagnostic and treatment services not otherwise available on a prepaid or insurance basis. The demand for ambulatory services of all types, although articulate, has been relatively ineffectual in motivating hospitals and clinics to establish such services. The absence of a financing mechanism for such services, which health insurance benefits could provide, is a basic reason for this continued gap in the organization of health care. The health sector, like any other part of the economy, is responsive to consumer demand backed by purchasing power.

Many existing ambulatory services are financed from tax funds, the eligibility for such services being determined by application of a "means

test." It is ironical that such organized programs, with established criteria for assuring a given quality of care, tend to fall more frequently in the public than in the private sector. The long-hoped-for realization of the hospital as a community center for health affairs has not materialized in part because the prepayment mechanism has not created the economic incentives for this development. This is one of the tasks of voluntary health insurance still to be acknowledged and implemented.

The sponsorship of this Conference, with its presentation of varied points of view, is a small step in a much larger undertaking to understand and interpret the forces underlying developments of medicine in transition. To the extent that the publication of these papers will promote further discussion, encourage exploration of new ideas, and provide stimulus for experimentation in the organization and financing of health services, the combined effort of all participants will have been worthwhile and rewarding. Without the generous grant from the Josiah Macy, Jr. Foundation, this publication would not have been possible nor could the inspiration of the Conference have been widely shared.

HARRY BECKER
Executive Secretary,
Committee on Special Studies